

Managed Care and HIV Disease

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As managed care becomes increasingly dominant in healthcare delivery, it becomes more and more important to understand how these systems perform for special populations, such as those with severe chronic illnesses. HIV disease raises numerous issues for managed care, including appropriate roles of specialist versus primary care providers; impact of providers' HIV-specific experience and "HIV-intensity" on outcomes; and definition and measurement of quality-of-care indicators.

In this issue of *The American Journal of Managed Care*, Mitchell Katz and his colleagues report on utilization of HIV health services in a San Francisco and Denver study population. Receipt of eight key services was similar among patients with fee-for-service (FFS), managed care, and public insurance (eg, Medicaid) coverage. Not surprisingly, utilization rates were lower for noninsured patients. Compared with fee-for-service, both managed care and public insurance patients were more likely than FFS patients to receive prophylaxis against pneumocystis carinii pneumonia (PCP); zidovudine treatment was significantly more prevalent for managed care patients than for FFS patients, with treatment rates comparable to those for public insurance. Interestingly, public insurance patients were most likely of the three groups to have received recent HIV-related medical care, a recent CD4 count, and screening for tuberculosis. The only indicator for which managed care compared unfavorably to FFS was receipt of pneumococcal vaccine.

In this study population, managed care provided access to care at least comparable to that received through FFS. Several caveats need to be considered in interpreting these findings. The managed care enrollees in this study are essentially a San Francisco population (93% are from that city). Most were gay white men with long-term residence in the area; compared to HIV patients nationally, they are a relatively well-educated group likely to be knowledgeable about HIV treatments and to be informed consumers of healthcare. Given the high prevalence of HIV dis-

ease in San Francisco, most are likely to receive care from providers with a high level of HIV experience. In the Bay Area, organizations such as Kaiser Permanente, a staff-model HMO with a high market share for HIV care in the area, have developed extensive protocols and multidisciplinary care teams for HIV care, and hospitals such as San Francisco General have high levels of HIV experience and have developed over the years centers of expertise including the nation's first dedicated AIDS inpatient unit.

Thus, as Katz et al note, the extent to which such results can be generalized to HIV care nationally remains to be determined. Their study is important because it is one of only a few that have documented quality and access indicators for HIV care in managed care systems. Of the limited literature, most has come from group-model HMO's such as Kaiser, Harvard Community Health Plan, and Group Health of Puget Sound.^{1,2} These studies generally suggest comparable rates of receipt of key services as with fee-for-service and comparable rates of patient satisfaction, but not necessarily lower cost of care. Few data are available on how persons with HIV are faring in the newer type of network managed care systems, although some data suggest reasons for concern. For example, studies in Maryland have found lower rates of PCP prophylaxis and antiretroviral therapy among Medicaid managed care patients, as compared with Medicaid fee-for-service patients.³

Data are also scarce on organizational approaches to providing HIV care in managed care systems. As HIV care in general has evolved, distinct care models have emerged that place a different spin on the primary care concept, such as the emergence of a primary-care-like role for infectious disease medicine, traditionally a sub-specialty. There is a need for more documentation of the ways in which the traditional model of the generalist primary care provider/gatekeeper has been modified for managed HIV care. In several states, specialized capitated systems are being developed for HIV care, but the development of such systems has

been constrained by scarcity of data for calculating appropriate capitation rates. In addition, little information is available on the extent to which managed care systems purchase care from HIV and infectious disease specialty clinics, such as those at university and public hospitals.

A related concern is whether managed care functions for educationally and economically disadvantaged individuals in the same way that it does for more knowledgeable consumers. Nationally, persons with HIV are an increasingly minority population with long-term histories of poverty, limited medical information, and limited education. HIV clinics that serve this population are called upon to provide assistance with numerous social services issues including assistance with benefits, housing, transportation, child care, and other issues. This is particularly the case for programs serving large numbers of women and children, a population not included in Katz et al's study. As Medicaid programs around the nation move toward mandatory managed care, their capacity to serve multiply disadvantaged persons with HIV disease will be tested. Many mandatory managed-care programs in Medicaid have initially exempted persons with HIV, but some, such as New York City's proposed waiver program, have not proposed automatic exemptions. This issue became controversial when, among other criticisms, a survey by New York's Housing Works reported that 955 of Medicaid managed care plans in the city could not refer callers to a primary care doctor with experience treating HIV and AIDS.⁴ In this instance, New York was requested by the Health Care Financing Administration to provide more information on capacity for HIV care, but under block-granting changes proposed by Congress such review requirements, and related data-collection requirements, would no longer exist.

While the New York City proposal for mandatory managed care relied on a "generic" managed care model, a route that is perhaps more promising that has been explored in some states has been the development of specialized, capitated managed care organizations designed to provide comprehensive HIV care. Such models may be particularly appropriate in areas where there has been extensive development of specialized programs offering HIV care and case management, often based at teaching hospitals. This

approach provided the ability to provide care to a "critical mass" of HIV patients and to maintain interdisciplinary care teams with incentives to encourage outpatient care and minimize reliance on inpatient care, which still accounts for the majority of HIV care costs nationally.

The study by Katz et al helps to narrow critical gaps in knowledge and suggests an agenda of urgent questions for further research on HIV and managed care. For inpatient care, a relationship between volume of HIV care and better outcomes has been established: does a similar relationship exist in ambulatory care? Is a "critical mass" of patients necessary for a given provider to attain optimal outcomes? Under what circumstances is referral to specialists necessary? What are the most appropriate indicators of care quality? How can receipt of "indicator services" such as those used by Katz and colleagues be monitored on an ongoing basis to compare quality across providers and payer systems, without the need for costly research studies or chart extraction? What type of encounter-level data will replace claims data for making such comparisons, as patients move out of fee-for-service to managed care systems? How can appropriate capitation rates be developed for HIV care that fairly compensate payers for the cost of evolving standard of care? With the increasing information systems capabilities of managed care organizations, such systems can serve as important study sites in helping to address these critical issues.

... REFERENCES ...

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